

No. 300
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5-17-39
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FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **31587**
Registrar's No. **2173**

FILED OCT 4 1948
Registration District No. **31945**

Primary Registration District No. **3069**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Mary's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 Weeks
(Specify whether years, months or days)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Frank J. Brune
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Cecelia
6. (c) Age of husband or wife if alive 62 years
7. Birth date of deceased February 5, 1884
(Month) (Day) (Year)

8. AGE: Years 64 Months 7 Days 13
If less than one day _____ hr. _____ min.

9. Birthplace Josephville Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Letter Carrier

11. Industry or business U.S.A.

12. Name Gerhard Brune
13. Birthplace Josephville Missouri
(State or foreign country)
14. Maiden name Mary Lantenne
15. Birthplace Josephville Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Cecelia Brune
(b) Address 725 Shenandoah Ave.

17. (a) Burial (b) Date thereof 9/21/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Resurrection Cemetery
John H. Gebken Sons and Co.

18. (a) Signature of funeral director _____
(b) Address 2630 Gravois Ave.

19. (a) 9-19-48 (b) Cecelia Brune
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. 725 Shenandoah Ave.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 18,
year 1948 hour 8, minute A M.

21. I hereby certify that I attended the deceased from June
1st, 1948, to Sept 18, 1948
that I last saw him, alive on Sept 17, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinomatosis
Due to Carcinoma Lung et
Due to 47d
Other conditions Carcinoma of Lymph
(Include pregnancy within 3 months of death)
nodes

Major findings: Carcinoma
Of operations Bronchoquies
Of autopsy Sause

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury 1

23. Signature John Stewart (M. D. or other) _____
Address 4660 Maryland Date signed 9-18-48

OCT 21 1948

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed Robert F. Gebken

Licensed Embalmer No. 4144

P. O. Address. 2630 Gravois Ave.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN-HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.